441—76.3(249A) Time limit for decision. Applications shall be investigated by the county department of human services. A determination of approval, conditional eligibility, or denial shall be made as soon as possible, but no later than 30 days following the date of filing the application unless one or more of the following conditions exist.

76.3(1) The application is being processed for eligibility under the medically needy coverage group as defined in 441—subrule 75.1(35). Applicants for medically needy shall receive a written notice of approval, conditional eligibility, or denial as soon as possible, but no later than 45 days from the date the application was filed.

76.3(2) An application on the client's behalf for supplemental security income benefits is pending.

76.3(3) The application is pending due to completion of the requirement in 441—subrule 75.1(7).

76.3(4) The application is pending due to nonreceipt of information which is beyond the control of the client or department.

76.3(5) The application is pending due to the disability determination process performed through the department.

76.3(6) Unusual circumstances exist which prevent a decision from being made within the specified time limit. Unusual circumstances include those situations where the county office and the applicant have made every reasonable effort to secure necessary information which has not been supplied by the date the time limit has expired or because of emergency situations such as fire, flood, or other conditions beyond the administrative control of the department.

441—76.4(249A) Notification of decision. The applicant or recipient will be notified in writing of the decision of the local office regarding the applicant's or recipient's eligibility for Medicaid. If the applicant or recipient has been determined to be ineligible an explanation of the reason will be provided.

76.4(1) The recipient shall be given a timely and adequate written notice as provided in 441—subrule 7.7(1) when any decision or action is being taken by the local office which adversely affects Medicaid eligibility or the amount of benefits.

76.4(2) Timely notice may be dispensed with but adequate notice shall be sent, no later than the effective date of action, when one or more of the conditions in 441—subrule 7.7(2) are met.

76.4(3) A written notice of decision shall be issued to the applicant the next working day following a determination of eligibility, conditional eligibility or ineligibility.

441—76.5(249A) Effective date.

76.5(1) *Three-month retroactive eligibility.*

a. Medical assistance benefits shall be available for all or any of the three months preceding the month in which the application is filed to persons who meet both of the following conditions:

(1) Have medical bills for covered services which were received during the three-month retroactive period.

(2) Would have been eligible for medical assistance benefits in the month services were received, if application for medical assistance had been made in that month.

b. The applicant need not be eligible in the month of application to be eligible in any of the three months prior to the month of application.

c. Retroactive medical assistance benefits shall be made available when an application has been made on behalf of a deceased person if the conditions in paragraph *"a"* are met.

d. Persons receiving only supplemental security income benefits who wish to make application for Medicaid benefits for three months preceding the month of application shall complete Form MA-2124-0, Supplementary Information—Medicaid Application—Retroactive Medicaid Eligibility.

e. Rescinded IAB 10/8/97, effective 12/1/97.

76.5(2) *First day of month.*

a. For persons approved for the family medical assistance-related programs, medical assistance benefits shall be effective on the first day of a month when eligibility was established anytime during the month.

b. For persons approved for supplemental security income, programs related to supplemental security income, or state supplementary assistance, medical assistance benefits shall be effective on the first day of a month when the individual was resource eligible as of the first moment of the first day of the month and met all other eligibility criteria at any time during the month.

c. When a request is made to add a new person to the eligible group, and that person meets the eligibility requirements, assistance shall be effective the first of the month in which the request was made.

d. When a request is made to add a person to the eligible group who previously was excluded, in accordance with the provisions of rule 441—75.59(249A), assistance shall be effective no earlier than the first of the month following the month in which the request was made.

76.5(3) *Care prior to approval.* No payment shall be made for medical care received prior to the effective date of approval.

441—76.6(249A) Certification for services. The department of human services shall issue a Medical Assistance Eligibility Card (Fee-for-Service), Form 470-1911, to persons determined to be eligible for the benefits provided under the Medicaid program unless one of the following situations exists:

76.6(1) *Lock-in.* The eligible person is receiving Medicaid under the recipient lock-in provisions defined at rule 441—76.9(249A). These persons shall be issued a Medical Assistance Eligibility Card (Lock-in), Form 470-3348, by the department.

76.6(2) *Managed care.* The eligible person is receiving Medicaid through any form of managed health care as defined at 441—Chapter 88. Those persons shall be issued Form 470-2213, Medical Assistance Eligibility Card (Managed Care).

76.6(3) *Aliens*. The eligible person is an alien who is receiving Medicaid only for emergency services as provided in rule 441—75.11(249A). These persons shall be issued a Medical Assistance Eligibility Card (Limited Benefits), Form 470-2188, by the department.

76.6(4) *Qualified Medicare beneficiary.* The eligible person is receiving Medicaid under the Qualified Medicare Beneficiary program. These persons shall be issued a Medical Assistance Eligibility Card (Limited Benefits), Form 470-2188, by the department.

These persons shall be eligible only for payment of Medicare premiums, deductibles, and coinsurance, as provided in 441—subrule 75.1(29).

76.6(5) *Pregnant woman.* The eligible person is a pregnant woman determined presumptively eligible in accordance with 441—subrule 75.1(30). These persons shall be issued a Presumptive Medicaid Eligibility Notice of Decision, Form 470-2580, by the department.

441—76.7(249A) Reinvestigation. Reinvestigation shall be made as often as circumstances indicate but in no instance shall the period of time between reinvestigations exceed 12 months.

The recipient shall supply, insofar as the recipient is able, additional information needed to establish eligibility within five working days from the date a written request is issued. The recipient shall give written permission for the release of information when the recipient is unable to furnish information needed to establish eligibility. Failure to supply the information or refusal to authorize the county office to secure information from other sources shall serve as a basis for cancellation of Medicaid.

Eligibility criteria for persons whose eligibility for Medicaid is related to the family medical assistance program shall be reviewed according to policies found in rule 441—75.52(249A).

Persons whose eligibility for Medicaid is related to supplemental security income shall complete Form 470-2927, Health Services Application, as part of the reinvestigation process when requested to do so by the county office.

The review for foster children or children in subsidized adoption shall be completed on Form 470-2914, Foster Care and Subsidized Adoption Medicaid Review, according to the time schedule of the family medical assistance program or supplemental security income program for disabled children, as applicable.

441—76.8(249A) Investigation by quality control or the food stamp investigation section of the department of inspections and appeals. The recipient or applicant shall cooperate with the department when the recipient's case is selected by quality control or the food stamp investigation section of the department of inspections and appeals for verification of eligibility unless the investigation revolves solely around the circumstances of a person whose income and resources do not affect medical assistance eligibility. (See department of inspections and appeals rules 481—Chapter 72.) Failure to do so shall serve as a basis for cancellation of assistance unless the Medicaid eligibility is determined by the Social Security Administration. Once denied or canceled for failure to cooperate, the person may reapply but shall not be determined eligible until cooperation occurs.

441—76.9(249A) Recipient lock-in. In order to promote high quality health care and to prevent harmful practices such as duplication of medical services, drug abuse or overuse, and possible drug interactions, recipients that utilize medical assistance services or items at a frequency or in an amount which is considered to be overuse of services as defined in subrule 76.9(7) may be restricted (locked-in) to receive services from a designated provider(s).

76.9(1) A lock-in or restriction shall be imposed for a minimum of 24 months with longer restrictions determined on an individual basis.

76.9(2) Provider selection. The recipient may select the provider(s) from which services will be received. The selection shall be made by using Form MA-4068, Designation of Primary Providers. The designated providers will be identified on the Medical Assistance Eligibility Card (Lock-in), Form 470-3348. Only prescriptions written or approved by the designated primary physician(s) will be reimbursed. Other providers of the restricted service will be reimbursed only under circumstances specified in subrule 76.9(3).

76.9(3) Payment will be made to provider(s) other than the designated (lock-in) provider(s) in the following instances:

a. Emergency care is required and the designated provider is not available. Emergency care is defined as care necessary to sustain life or prevent a condition which could cause physical disability.

b. The designated provider requires consultation with another provider. Reimbursement shall be made for office visits only. Prescriptions will be reimbursed only if written or approved by the primary physician(s). Referred physicians may be added to the designation as explained in subrule 76.9(5).

c. The designated provider refers the recipient to another provider. Reimbursement shall be made for office visits only. Prescriptions will be reimbursed only if written or approved by the primary physician(s). Referred physicians may be added to the designation as explained in subrule 76.9(5).

76.9(4) When the recipient fails to choose a provider(s) within 30 days of the request, the division of medical services will select the provider(s) based on previously utilized provider(s) and reasonable access for the recipient.

76.9(5) Recipients may change designated provider(s) when a change is warranted, such as when the recipient has moved, the provider no longer participates, or the provider refuses to see the patient. The worker for the recipient shall make the determination when the recipient has demonstrated that a change is warranted. Recipients may add additional providers to the original designation with approval of a health professional employed by the department for this purpose.

76.9(6) When lock-in is imposed on a recipient, timely and adequate notice shall be sent and an opportunity for a hearing given in accordance with 441—Chapter 7.

76.9(7) Overuse of services is defined as receipt of treatments, drugs, medical supplies or other Medicaid benefits from one or multiple providers of service in an amount, duration, or scope in excess of that which would reasonably be expected to result in a medical or health benefit to the patient.

a. Determination of overuse of service shall be based on utilization data generated by the Surveillance and Utilization Review Subsystem of the Medicaid Management Information System. The system employs an exception reporting technique to identify the recipients most likely to be program overutilizers by reporting cases in which the utilization exceeds the statistical average.

b. In addition to referrals from the Surveillance and Utilization Review Subsystem described in paragraph *"a,"* referrals for utilization review shall be made when utilization data generated by the Medicaid Management Information System reflects utilization of Medicaid recipient outpatient visits to physicians, family and pediatric nurse practitioners, federally qualified health centers, rural health centers, other clinics, and emergency rooms exceeds 24 visits in any 12-month period. This utilization review shall not apply to Medicaid recipients who are enrolled in the MediPASS program or a health maintenance organization, or who are children under 21 years of age or residents of a nursing facility. For the purposes of this paragraph, the term "physician" does not include a psychiatrist.

c. An investigation process of Medicaid recipients determined in paragraphs *"a"* or *"b"* to be subject to a review of overutilization shall be conducted to determine if actual overutilization exists by verifying that the information reported by the computer system is valid and is also unusual based on professional medical judgment. Medical judgments shall be made by physicians, pharmacists, nurses and other health professionals either employed by, under contract to, or consultants for the department. These medical judgments shall be made by the health professionals on the basis of the body of knowledge each has acquired which meets the standards necessary for licensure or certification under the Iowa licensing statutes for the particular health discipline.

441—76.10(249A) Applicant and recipient responsibilities.

76.10(1) An applicant or recipient eligible for Medicaid because of income and resource policies related to the supplemental security income (SSI) program, except for actual recipients of SSI, shall timely report any changes in the following circumstances to the department:

a. Income from all sources.
b. Resources.
c. Membership of the household.
d. Recovery from disability.
e. Mailing or living address.
f. Health insurance premiums or coverage.
g. Medicare premiums or coverage.
h. Receipt of social security number.
i. Gross income of the community spouse or dependent children, parents or siblings of the institutionalized or community spouse living with a community spouse when a diversion is made to the community spouse or family. (See definitions in rule 441—75.25(249A).)
j. Income and resources of parents and spouses when income and resources are used in determining Medicaid eligibility, client participation or spenddown.
k. Residence in a medical institution for other than respite care for more than 15 days for home and community-based recipients.

76.10(2) An applicant or recipient eligible for Medicaid because of the family medical assistance program (FMAP) income and resource policies shall report changes in accordance with 441—paragraphs 75.52(4)*"c"* through *"e."* After assistance has been approved, changes occurring during the month are effective the first day of the next calendar month, provided the notification requirements at rule 441—76.4(249A) can be met.

76.10(3) A report shall be considered timely when received in the local office within ten days from the date the change is known to the recipient or authorized representative and within five days from the date the change is known to the applicant or authorized representative.

76.10(4) When a change is not timely reported, any incorrect program expenditures shall be subject to recovery from the recipient.

76.10(5) Effective date of change. When a request is made to add a new person to the eligible group, and that person meets the eligibility requirements, assistance shall be effective the first day of the month in which the request was made unless otherwise specified at rule 441—76.5(249A). After assistance has been approved, changes reported during the month shall be effective the first day of the next calendar month, unless:

a. Timely notice of adverse action is required as specified in 441—subrule 7.7(1).

b. The certification has expired for persons receiving assistance under the medically needy program in accordance with the provisions of 441—subrule 75.1(35).

c. Rescinded IAB 10/31/01, effective 1/1/02.

441—76.11(249A) Automatic redetermination. Whenever a Medicaid recipient no longer meets the eligibility requirements of the current coverage group, an automatic redetermination of eligibility for other Medicaid coverage groups shall be made. If the reason for ineligibility under the initial coverage group pertained to a condition of eligibility which applies to all coverage groups, such as failure to cooperate, no further redetermination shall be required. When the redetermination is completed, the recipient shall be notified of the decision in writing. The redetermination process shall be completed as follows:

76.11(1) *Information received by the tenth of the month.* If information that creates ineligibility under the current coverage group is received in the county office by the tenth of the month, the redetermination process shall be completed by the end of that month unless the provisions of subrule 76.11(3) apply. The effective date of cancellation for the current coverage group shall be the first day of the month following the month the information is received.

76.11(2) *Information received after the tenth of the month.* If information that creates ineligibility under the current coverage group is received in the county office after the tenth of the month, the redetermination process shall be completed by the end of the following month unless the provisions of subrule 76.11(3) apply. The effective date of cancellation for the current coverage group shall be the first day of the second month following the month the information is received.

76.11(3) *Change in federal law.* If a change in federal law affects the eligibility of large numbers of Medicaid recipients and the Secretary of Health and Human Services has extended the redetermination time limits, in accordance with 42 CFR Sec. 435.1003 as amended to January 13, 1997, the redetermination process shall be completed within the extended time limit and the effective date of cancellation for the current coverage group shall be no later than the first day of the month following the month in which the extended time limit expires.

76.11(4) *Referral for HAWK-I program.* When the only coverage group under which a child will qualify for Medicaid is the medically needy program with a spenddown as provided in 441—subrule 75.1(35), a referral to the Hawk-I program shall be made in accordance with 441—subrule 86.4(4) as part of the automatic redetermination process when it appears the child is otherwise eligible.

441—76.12(249A) Recovery.

76.12(1) *Definitions.*

"Administrative overpayment" means medical assistance incorrectly paid to or for the client because of continuing assistance during the appeal process or allowing a deduction for the Medicare part B premium in determining client participation while the department arranges to pay the Medicare premium directly.

"Agency error" means medical assistance incorrectly paid to or for the client because of action attributed to the department as the result of one or more of the following circumstances:

1. Misfiling or loss of forms or documents.
2. Errors in typing or copying.
3. Computer input errors.
4. Mathematical errors.
5. Failure to determine eligibility correctly or to certify assistance in the correct amount when all essential information was available to the county office.
6. Failure to make prompt revisions in medical payment following changes in policies requiring the changes as of a specific date.

"Client" means a current or former applicant or recipient of Medicaid.

"Client error" means medical assistance incorrectly paid to or for the client because the client or client's representative failed to disclose information, or gave false or misleading statements, oral or written, regarding the client's income, resources, or other eligibility and benefit factors. It also means assistance incorrectly paid to or for the client because of failure by the client or client's representative to timely report as defined in rule 441—76.10(249A).

"Department" means the department of human services.

76.12(2) *Amount subject to recovery.* The department shall recover from a client all Medicaid funds incorrectly expended to or on behalf of the client. The incorrect expenditures may result from client or agency error, or administrative overpayment.

76.12(3) *Notification.* All clients shall be promptly notified when it is determined that assistance was incorrectly expended. Notification shall include for whom assistance was paid; the time period during which assistance was incorrectly paid; the amount of assistance subject to recovery; and the reason for the incorrect expenditure.

76.12(4) *Source of recovery.* Recovery shall be made from the client or from parents of children under age 21 when the parents completed the application and had responsibility for reporting changes. Recovery may come from income, resources, the estate, income tax refunds, and lottery winnings of the client.

76.12(5) *Repayment.* The repayment of incorrectly expended Medicaid funds shall be made to the department.

However, repayment of funds incorrectly paid to a nursing facility, a Medicare-certified skilled nursing facility, a psychiatric medical institution for children, an intermediate care facility for the mentally retarded, or mental health institute enrolled as an inpatient psychiatric facility may be made by the client to the facility. The department shall then recover the funds from the facility through a vendor adjustment.

76.12(6) *Appeals.* The client shall have the right to appeal the amount of funds subject to recovery under the provisions of 441—Chapter 7.

76.12(7) *Estate recovery.* Pursuant to Iowa Code section 249A.5(2), medical assistance is subject to recovery from the estate of the recipient, a surviving spouse, or a surviving child as provided below.

a. The provision of medical assistance to a Medicaid recipient who is either 55 years of age or older or a resident of a nursing facility, intermediate care facility for the mentally retarded, or a mental health institute who cannot reasonably be expected to be discharged and return home creates a debt due the department from the recipient's estate for all medical assistance provided on the recipient's behalf on or after July 1, 1994, upon the recipient's death.

The department shall presume that a Medicaid recipient who is under 55 years of age and a resident of a nursing facility, intermediate care facility for the mentally retarded, or a mental health institute cannot reasonably be expected to be discharged and return home unless the recipient requests that the department determine whether the recipient can reasonably be expected to return home. If a written request is made, the department shall determine whether the recipient can reasonably be expected to return home.

The department shall send notice to a Medicaid recipient who is under 55 years of age and a resident of a nursing facility, intermediate care facility for the mentally retarded, or a mental health institute that the recipient will be presumed to be unable to return home unless the recipient requests in writing within 30 calendar days of the date of the notice that a determination be made whether the recipient can reasonably be expected to return home. If a request is made, the Iowa Foundation for Medical Care (IFMC) shall make the determination and notify the recipient of the decision. Appeals of adverse decisions made by IFMC shall be directed first to IFMC for reconsideration. An appeal of an adverse reconsideration decision by IFMC shall then be directed to the department pursuant to 441—Chapter 7.

The request for review of an IFMC determination of whether the recipient can reasonably be expected to be discharged and return home shall be forwarded to IFMC by the department only after the person has resided in the care facility for a period of six consecutive months. If IFMC determines that the recipient could not reasonably be expected to be discharged and return home, IFMC shall provide information to the department regarding whether the client was ever reasonably expected to be able to return home within the first six months of institutionalization and the date the expectation and ability to return home ceased.

If the recipient is discharged from the facility and returns home before six consecutive months, no debt will be assessed for Medicaid payments made on the recipient's behalf for the time of the institutionalization.

If a client dies before six consecutive months of institutionalization, the family or other interested party may submit a written request to rebut the presumption that the recipient could reasonably have been expected to be discharged and return home. If IFMC determines that the recipient could not reasonably be expected to be discharged and return home, the family may appeal the adverse decision first to IFMC for reconsideration. An adverse reconsideration decision by IFMC may then be appealed to the department pursuant to 441—Chapter 7. If the IFMC determination is overturned, no debt is due from the date of admission or the effective date of a determination that the individual could not reasonably be expected to return home. If IFMC is upheld, a debt is due from the recipient's estate as of the date the recipient could not reasonably be expected to be discharged and return home.

If the recipient fails to make the request within the 30 calendar days, the recipient may make a request at a later date. However, if the determination is then made that the recipient is reasonably able to return home, assistance received before the date of the request is still subject to estate recovery.

b. The department shall waive the collection of the debt created under this subrule from the estate of the recipient to the extent that collection of the debt would result in either of the following:

(1) Reduction in the amount received from the recipient's estate by a surviving spouse, or by a surviving child who is under the age of 21, blind, or permanently and totally disabled at the time of the recipient's death.

(2) Creation of an undue hardship for the person seeking a waiver of estate recovery. Undue hardship exists when total household income is less than 200 percent of the poverty level for a household of the same size, total household resources do not exceed $10,000, and application of estate recovery would result in deprivation of food, clothing, shelter, or medical care such that life or health would be endangered as determined by the department on a case-by-case basis. For this purpose, income and resources shall be defined as under the family medical assistance program.

(3) To apply for a waiver of estate recovery due to undue hardship, the person shall provide a written statement and supporting verification to the department within 30 days of the notice of estate recovery pursuant to Iowa Code section 633.425.

Appeals of adverse decisions regarding an undue hardship determination may be filed in accordance with 441—Chapter 7.

c. If collection of all or part of a debt is waived pursuant to paragraph *"b,"* the amount waived shall be a debt due from the estate of the recipient's surviving spouse or blind or disabled child or of the person who received a hardship waiver under subparagraph (2), upon the death of the spouse, child, or person with a hardship waiver, or due from a surviving child who was under 21 years of age at the time of the recipient's death, upon the child's reaching the age of 21, to the extent the recipient's estate is received by the surviving spouse, child, or person with a hardship waiver.

d. Interest shall accrue on a debt due under this subrule at the rate provided pursuant to Iowa Code section 535.3, beginning six months after the death of a Medicaid recipient, surviving spouse, or surviving child, or upon the child's reaching the age of 21.

e. For these purposes, the "estate" of a Medicaid recipient, surviving spouse, or surviving child shall include all real property, personal property, or any other asset in which the recipient, spouse, or surviving child had any legal title or interest at the time of the recipient's, spouse's or child's death, or a child's reaching the age of 21, to the extent of the interest, including, but not limited to, interest in jointly held property, retained life estates, and interests in trusts. All assets included in the estate of a Medicaid recipient, surviving spouse, or surviving child are subject to probate for the purposes of medical assistance estate recovery pursuant to Iowa Code section 249A.5(2)*"d."*

f. The estate of an individual who is eligible for Medicaid under 441—subrule 75.5(5) shall not be subject to a claim for assistance paid on the recipient's behalf up to the amount of the assets disregarded by asset disregard. Medicaid paid on behalf of the recipient prior to these conditions shall be recovered from the estate regardless of the recipient having purchased precertified or approved insurance.

g. If a county reimburses the department for medical assistance provided under this subrule and the amount of medical assistance is subsequently repaid through a medical assistance income trust or a medical assistance special needs trust as defined in Iowa Code section 633.707, the department shall reimburse the county on a proportionate basis.

The classification of debt for medical assistance paid pursuant to 249A.5, subsection 2, is defined at Iowa Code section 633.425.

441—76.13(249A) Conversion to the X-PERT system. Rescinded IAB 10/31/01, effective 1/1/02.

These rules are intended to implement Iowa Code sections 249.3, 249.4, 249A.4 and 249A.5.

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